PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council held Tuesday, September 21, 2004, 10:00 a.m., at the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Commissioner Christine C. Ferguson, Chair, Ms. Phyllis Cudmore, Mr. Manthala George, Jr., Ms. Maureen Pompeo, Mr.Albert Sherman, Ms. Janet Slemenda, Dr. Thomas Sterne, Mr. Gaylord Thayer, Jr. and Dr. Martin Williams. Also in attendance was Attorney Donna Levin, General Counsel.

Chair Ferguson announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, chapter 30A, section 11A ½.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Ms. Nancy Ridley, Assistant Commissioner/Director, Betsy Lehman Center and Principle Investigator for Patient Safety; Ms. Karen Granoff, Director, Office of Patient Protection; Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control; Ms. Joyce James, Director, Mr. Jere Page, Senior Analyst, Determination of Need Program; and Deputy General Counsel, Carol Balulescu, Office of the General Counsel.

In letters dated September 10, 2004, Val W. Slayton, MD, MPP, Interim Director of Medical Services, Tewksbury Hospital, Tewksbury, recommended approval of the appointments and reappointment to the various medical and allied health staffs of Tewksbury Hospital. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with recommendation of the Interim Director of Medical Services of Tewksbury Hospital, under the authority of the Massachusetts General Laws, chapter 17, section 6, the following appointments and reappointment to the various medical and allied health staffs of Tewksbury Hospital be approved for a period of two years beginning September 1, 2004 to September 1, 2006:

APPOINTMENTS:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
Haleh Rokni, MD	213066	Affiliate Psychiatry
David Rubin, MD	220827	Affiliate Psychiatry
Ronald White, MD	46552	Active Psychiatry
REAPPOINTMENT:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
Justin Mohatt, MD	214886	Affiliate Psychiatry

In a letter dated September 13, 2004, Paul Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of the appointments and reappointments to the various medical staffs of Lemuel Shattuck Hospital. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the

Massachusetts General Laws, chapter 17, section 6, the following appointments and reappointments to the various medical staffs of Lemuel Shattuck Hospital be approved:

APPOINTMENTS:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
Crispin Valiente, MD	39930	Active/Anesthesiology
John Bernardo, MD	44145	Consultant/Pulmonary Medicine
Mary Frekko, MD	221967	Consultant/Internal Medicine
Neil Sanghvi, MD	222819	Consultant/Internal Medicine
Lori Schleicher, MD	221532	Consultant/Internal Medicine
William Slaughter, MD	220004	Consultant/Psychiatry
Stanton Wolfe, DDS	14083	Consultant/Dentistry
Elise Kline, CNS	120791	Allied Health Professional
REAPPOINTMENTS:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
Nicolaos Athienites, MD	73425	Active/Internal Medicine; Nephrology
Maureen Malin, MD	56998	Consultant/Psychiatry
Ernst Manigat, MD	157166	Consultant/Psychiatry
William McCarthy, CNS	108098	Allied Health Professional

STAFF PRESENTATION: "PATIENT PROTECTION MANAGED CARE DATA 2003-2004":

Ms. Karen Granoff, Director, Office of Patient Protection, presented patient protection and managed care data to the Council via a slide show. Ms. Granoff noted in part, "The Office of Patient Protection was created in 2000 as a result of a law signed by Governor Cellucci. In addition to overseeing the internal appeal process of health plans, we are also responsible for several other provisions in Chapter 176O, including continuity of care provisions, overseeing collection and interpretation of data on managed care, and posting data on our web site. The law was originally Chapter 141. It was added to the General Laws as Chapter 176O. One thing that people are often not aware of is that the law only applies to certain people. Chapter 176O applies to commercial health plans that are written in the Commonwealth of Massachusetts, issued or delivered in the Commonwealth of Massachusetts. It does not apply to people who have Medicaid, Mass. Health, Medicare, or people in self-funded health plans and federal employees. There is a good chunk of folks who live in Massachusetts, who do not have access to any of the provisions under this law…They have other appeal laws under the federal government but not Massachusetts."

Ms. Granoff continued, "The other part of the Office of Patient Protection is the Managed Care Ombudsmen. We have Stephanie Carter and Joanne McGinn – they take phone calls from patients, and providers on issues that have to do with referrals, denials of care, authorization and where to go with issues. They refer people to the right place if they don't have access under 176O…There are two important definitions that come under the law, that are really the basis of the whole appeals and grievance process. The first is an adverse determination…adverse determination is defined in the law as a determination to deny, reduce, modify or terminate an admission, continued inpatient stay, for the availability of other health services based on failure to meet requirements based on medical

necessity. It is what a lot of people refer to as a medical necessity denial, and it could be a health plan saying, we don't think you need to be in the hospital anymore. It can be a health plan saying, we don't believe that you need to have this particular surgical procedure, or we don't believe that inpatient stay is necessary. We think that residential care would be appropriate in this case. It is any of those types of medical necessity denials."

Ms. Granoff further stated, "Medical necessity is also very specifically defined in our law as health care practices that are consistent with generally accepted principles. They have to be the most appropriate available supply for the insured in question. They have to be shown to be effective based on scientific evidence for professional standards and expert opinion. And then, for services that are not in widespread use, they have to be based on scientific evidence. So when, an external review agency is reviewing a case, they need to back it up with documentation, peer review literature, scientific evidence, etc. It can't just be, in my practice, this is what we do. It has to go beyond that. The interesting thing about the way this law was written is that, for the appeals and grievance piece of the law, it divided regulated authority between the Department of Public Health and the Division of Insurance. The Division of Insurance is responsible for the initial adverse determination piece. That is the part where the doctor calls the health plan and says, I want to admit Mrs. Jones for such and such, and the health plan either approves it or issues what we call an initial adverse determination or medical necessity denial. If they do deny it, they have to provide that information in writing and they have to include in the letter not just that it is being denied, but what medical criteria it doesn't meet. They have to reference and include those criteria. They have to let people know that the Office of Patient Protection is available, and that there is an appeal process, if they disagree with the decision. It was noted that the health plan must issue a written decision within 24 hours to a provider. People then have the option to go to the health plan and file an appeal (an internal grievance)…A person must notify the health plan in writing, by telephone or electronic means. If medical records are required, then the time period begins once the health plan receives back the consent to release medical records. It is thirty days from that point. Otherwise thirty days from the date the patient requested grievance, however if the patient's health can't wait for thirty days, the health plan has to be able to do that on an expedited basis."

Ms. Granoff continued, "The carrier has to continue coverage while the internal appeal is pending, if it is something they initially approved (i.e., physical therapy mental health visits, inpatient stays that are already in progress). If the appeal process still determines that the coverage is not necessary, that is when the patient has to be given external review information. The plan will issue a Final Adverse Determination Letter and it must include all of the data in the original adverse determination letter and information about the Office of Patient Protection. It has to include the form for an external review. It has to explain why they are not approving it, the criteria used; and if there is an alternative treatment, that has to be in there too. So, a letter may say, 'We don't believe that inpatient care is necessary. However, we would cover partial hospitalization for this patient. When the request comes to the Office of Patient Protection, it has to be within 45 days of when the patient receives the final adverse determination. It has to include the form. It has to include release of information so that we can get medical information, or the carrier can get medical information on the patient. We have to include a copy of the final adverse determination. There is a twenty-five dollar filing fee, which is waived for financial hardship; and most importantly, and this is one of the reasons that we have to screen the cases, it cannot include a request for services or benefits that are excluded from coverage (i.e., acupuncture). When an external review agency gets the case, what they are looking

at is (1) whether the service is medically necessary and (2) is it a covered benefit under the health plan. If it is an exclusion, there is no point sending it to review."

Ms. Granoff further explained, "We screen the new cases that we get to make sure that they meet the requirements under the regulations. We will often work with the carrier to get additional information. We sometimes see situations where we will call the carrier and say, do you want to reconsider this before we send it out? You might not have noticed this, or you might not have this piece of information. We work collaboratively with most of the health plans so that, if we can avoid sending something for external review, and resolve it favorably for all the parties, we will do that. It also gives us an opportunity to identify problems, to identify where a plan may not be in compliance, to identify operational problems and other issues, and if we do have ongoing problems, we refer cases to the Division of Insurance. They are the ultimate enforcement agency for health plans licensed in Massachusetts, and we work very closely with them." It was noted that the patient or authorized representative can file the external review request. For instance, particularly behavioral health, it is almost always someone from the hospital filing it on behalf of the patient.

Ms. Granoff noted that her office also inspects grievance files in health plans to ensure compliance with the law. The good news is the health plans are doing want they are supposed to be doing and they found very few problems. The Office of Patient Protection also issues advisories to the external review agencies to improve the quality of the decisions they get; and do outreach to professional organizations, hospitals and provider groups to increase the awareness of their office. They have contacted every psychiatric hospital in Massachusetts and many acute care hospitals. They work closely with the Division of Insurance to discuss issues and work on particular cases. They work with the Department of Mental Health on behavioral health issues, and we work with the Office of the Attorney General on particular health plan problems and other state agencies to identify issues, trends and to make sure they are all on the same page.

Ms. Granoff continued and discussion followed by the Council. The following facts were noted:

- The OPP contracts with three external review agencies (the same three since the Office began in 2001). The cost of a review is anywhere from about $400.00 to $700.00 , depending on whether it is a standard review of 60 business days or an expedited review of five business days. The cost of the review is paid for by the health plan, except for the $25.00 patient filing fee;

- Between 2001 and the subsequent two years, OPP had a large increase in cases. In 2004, the first six months indicates a much smaller volume of cases due to the change in the number of behavioral health cases that have been received. In 2003, OPP had a large number of cases from one health plan. OPP and other state agencies worked with the health plan and the health plan agreed to work on their review process and now OPP has very few appeals from that health plan;

- It was noted for behavioral health that if a person falls under the parity part of the law (12 diagnoses such as a biologically based illness) then there is no limit to outpatient visits for a medical necessity;

- The majority of behavioral health cases are for termination of inpatient benefits, residential benefits or patients whose doctors feel should be in a particular setting the health plan is not allowing them to access. There are not very many outpatient appeals;

- In 2001, 24% of the cases were overturned; in 2003 almost 50% of the cases were overturned. In 2003, the vast majority of the cases were behavioral health; If you just look at behavioral health in 2003, almost 60% of the cases were overturned;

- Behavioral Health is the number one category of complaints with a higher overturn rate than other categories; followed by four other categories that rotate being number two, three or four: infertility (is this condition due to age or is it a medical condition which is covered under the state mandate); experimental; cosmetic/reconstructive; and rehabilitation services (speech therapy, physical therapy);

- If a health plan will not cover something it considers to be experimental, OPP automatically sends out the appeal to an external review agency to decide whether or not it is indeed considered experimental or not;

- Most health plans consider physical therapy to be a short term benefit limited to 60 or 90 consecutive days and anything beyond that is not covered;

- For early intervention services, one has the option to contact OPP or the state office of Early Intervention Program for help in obtaining further services for their child. It was noted that private health insurance covers the first $5,000 and the state will cover anything beyond that.

NO VOTE/INFORMATION ONLY

PROPOSED REGULATIONS:

INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO HOSPITAL LICENSURE REGULATIONS GOVERNING THE DESIGNATION OF TRAUMA CENTERS – 105 CMR 130.000:

Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control, presented an Informational Briefing on Proposed Regulations Governing the Designation of Trauma Centers – 105 CMR 130.000. He noted that the proposed amendment removes the explicit timelines from the regulation, and allows the Department to set out in guidelines the timeframes for ACS verification that hospitals must meet in order to be designated as trauma centers. He further explained the reason for the proposed change in the current regulations, "Last February the Department adopted regulations governing the designation of trauma centers. The primary criterion for designation was verification by the American College of Surgeons (ACS); that is, hospitals that successfully completed the ACS process and received formal verification met one of the criteria for designation as a trauma center." As the staff in the Center worked to implement the regulations, it has become apparent that the timelines set out for ASC verification are not feasible. In particular, the ACS will not accept formal applications for verification until it has reviewed six months of trauma data. This policy makes it virtually impossible for any hospital not already well into the ACS verification

process to meet the timelines contained in the regulation. What we have decided to do is to take the explicit time lines out of the regulations and develop guidelines that make it clear the standards that hospitals will have to meet in order to be verified."

NO VOTE/INFORMATION ONLY

INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO 105 CMR 172.000 – IMPLEMENTATION OF M.G.L.C.111,§111C, REGULATING THE REPORTING OF INFECTIOUS DISEASES DANGEROUS TO THE PUBLIC HEALTH:

Attorney Carol Balulescu, Deputy General Counsel, Office of the General Counsel, presented the proposed amendments to 105 CMR 172.000 regulating the reporting of infectious diseases dangerous to the Public Health. She noted, "Section 111C of M.G.L.c.111 provides that Emergency Medical Services (EMS) workers who attend, assist or transport a person to a health care facility licensed by the Department, and who sustain an unprotected exposure capable of transmitting a bloodborne disease dangerous to the public health, must report such an exposure to the facility. The facility in turn, must notify those EMS workers if in fact the person who was treated and/or transported is diagnosed with a bloodborne disease dangerous to the public health, and that they have therefore been exposed to such disease. The Department is charged with promulgating regulations that, inter alia, define "infectious diseases dangerous to the public health." Pursuant to this authority, the Department previously promulgated 105 CMR 172.000. In addition to defining those diseases, the regulation provides that EMS workers receive notification via a designated infection control officer at their ambulance services, emergency first response (EFR) services, or first responder agencies. The regulation also sets forth a means by which a health care facility will notify the infection control officer at the service or agency if a patient is diagnosed with an airborne or other infectious disease to which an EMS worker was exposed. In its current form the regulation lists those diseases that were determined to be dangerous to the public health for the notification purposes of section 111C as of July 2003. The Department now proposes to add several other diseases to the list. Additionally, the Department is proposing to add a new section to the regulation, similar to 105 CMR 300.150, which appears in 105 CMR 300.000, Reportable Diseases, Surveillance, and Isolation and Quarantine Requirements. This new section will permit the Department to immediately add a new disease to the list, but only for a maximum period of twelve months. This will enable the Department to act quickly in the event that a new disease, like SARS, appears, but also guarantees that within twelve months of such action the Department must comply with the procedural requirements of M.G.L.c.30A, including holding a public hearing, to permanently amend the regulation."

In conclusion, Attorney Balulescu said, "The proposed amendments will add Severe Acute Respiratory Syndrome (SARS), smallpox, monkeypox and infection with any other orthopox virus in humans (including vaccinia) to the list of infectious diseases in the regulation. Additionally, the amendments will provide that the Commissioner of Public Health may declare other newly recognized or recently identified infectious diseases as infectious diseases dangerous to the public health and subject to the provisions of 105 CMR 172.000 for a period of time not to exceed 12 months. The Department plans to hold a public hearing for comments on the proposed amendments on October 19, 2004, and will return to the Council with a final recommendation."

No Vote Information Only

PROJECT APPLICATION NO. 2-1469 OF SAINT FRANCIS HOME

Mr. Jere Page, Senior Program Analyst, Determination of Need Program, presented the Saint Francis House application to the Council. Mr. Page said in part, "…The application proposes construction of a three-story addition to the existing 28 Level IV bed Mercy Center located at 101 Barry Road, Worcester, MA to replace and relocate 120 Level II beds from the existing 137 Level II bed Saint Francis Home located at 101 Plantation Street in Worcester, MA. The project also involves substantial renovation of the Mercy Center to convert existing residential space to administrative offices and patient rehabilitation and activity services, and upgrade the dietary and laundry services…The recommended maximum capital expenditure is $11,663,575 (January 2004) dollars and first year operating costs of $543,159 (January 2004 dollars). Five Ten Taxapayer Groups registered on the application and submitted written comments opposing the project. A public hearing was not requested. The TTGs wrote that Saint Francis is considered an historical landmark with an exceptionally good reputation for care of the elderly. They contend that it would be more practical to renovate the existing 100 year-old facility, which is in good condition and could be renovated for significantly less than construction of a new $12 million facility on the other side of Worcester. Some of the TTGs' members are residents of the nursing home or have relatives as residents there, and have expressed concern that their lives will be severely disrupted by the proposed relocation and see no benefit in leaving the present neighborhood. The TTGs are also concerned about the joining of Saint Francis Home with the Mercy Center, which is owned and operated by the Sisters of Mercy, a different religious order. Based on these concerns, the TTGs recommend denial of the project…."

In the staff's summary, Mr. Page wrote, "In responding to the TTG's assertion that renovation of the existing Saint Francis Home would be a less costly alternative to relocation of its beds to the Mercy Center, Staff's analysis under the health care requirements review factor shows that the proposed project has met the criteria for replacement and relocation of beds specified by the Determination of Need Nursing Facility Replacement and Renovation Guidelines. For example, a significant portion of the existing Saint Francis Home was constructed over 96 years ago, and the facility has significant physical and operational inefficiencies to the extent that it can no longer effectively accommodate the medical, social and safety needs of its residents. Further, Staff's analysis under the relative merit factor shows that the applicant has investigated the possibility of a complete renovation of the Saint Francis facility, determined that it would be beyond the scope of its financial and operational abilities, mainly because of significant lost revenue and staff layoffs during construction, as well as the possible transfer of 60 residents to other facilities during the renovation process. In addition, the applicant reports that the new facility will provide a more optimal quality of life and more efficient operation than the existing facility. For example, the new facility will have 40-bed nursing units as opposed to the 20-bed units in the existing facility, which will require less staffing, as well as modern utilities such as air conditioning, which is not present in the existing facility. Regarding possible disruption of the lives of residents and their families because of relocation, Staff notes that the new facility will be approximately five miles from the existing Saint Francis Home, and that the applicant has pledged that existing Saint Francis residents will receive the same high quality of care in the new facility as they currently receive. Regarding Saint Francis Home joining the Mercy Center, the applicant has confirmed that after the new facility is licensed, Saint Francis will be the

owner and operator of the new facility and will be governed by its own Board of Directors. After careful consideration of the TTG's concerns, Staff continues to recommend approval in part with conditions of this application." The Ten Taxpayer Groups did not testify at the Public Health Council Meeting. The applicant represented by Sister Anna Tag did not make a presentation but was available for questions (no questions asked). Staff responded to questions by Dr. Sterne regarding the environmental impact of the project. Staff explained the notification form checklist filled out by DoN applicants. The form was developed together with the Mass. Environmental Protection Agency (MEPA). If the checklist indicates that a MEPA Notification Form is needed then DoN staff requires a condition of approval that the applicant comply with MEPA regulations before final plan approval of the project.

After consideration upon motion made and duly seconded, it was voted (unanimously) to approve **Project Application No. 2-1469 of Saint Francis Home, Worcester**; based on staff findings, with a maximum capital expenditure of $11,663,575 (January 2004 dollars) and first year operating costs of $543,159 (January 2004 dollars). The staff summary is attached and made a part of this record as **Exhibit NO. 14,795**. As approved, the application provides for new construction of a three story addition to the existing 28 Level IV bed Mercy Center located at 101 Barry Road, Worcester, MA, to replace and relocate 120 Level II beds from the existing 137 Level II bed Saint Francis Home located at 101 Plantation Street in Worcester, MA. The project involves substantial renovation of Mercy Center to convert existing residential space to administrative offices and patient rehabilitation and activity services, and upgrade the dietary and laundry services. The resulting total bed complement will be 120 Level II and 28 Level IV beds…This Determination is subject to the following conditions:

1. The applicant shall accept the maximum capital expenditure of $11,663,575 (January 2004 dollars) as the final cost figure except for those increases allowed pursuant to 105 CMR 100.751 and 752.

2. The total approved GSF for this project is 85,300 GSF: 55,500 GSF for new construction to replace and relocate 120 Level II beds; and 29,800 GSF for substantial renovation to convert existing residential space to administrative offices and patient rehabilitation and activity services, and upgrade the dietary and laundry services.

3. The applicant shall, prior to construction, sign a formal affiliation agreement with at least one local acute care hospital and one local home care corporation that addresses provision for respite services.

4. The applicant shall establish a plan to protect the privacy, health and safety of the residents of the Mercy Center facility during the new construction and renovation process.

5. The applicant shall guarantee beds in the new facility for residents residing in the existing Saint Francis Home.

6. The applicant shall ensure that Medicaid transfers from the existing Saint Francis Home to the new facility will continue to receive care until such time that Medicaid certification is

obtained.

7. Upon implementation of the project, any assets such as land, building improvements, or equipments, or equipment which are either destroyed or no longer used for patient care, shall not be claimed for reimbursement for publicly aided patients.

8. The Department shall reserve the right to conduct a review of the financial feasibility of the project based on the Division of Health Care Finance and Policy's established rates of reimbursement for Medicaid patients at the time final maximum capital expenditures or any adjustments to the final maximum capital expenditures are submitted to the Determination of Need Program for approval in the event that such expenditures exceed the approved maximum capital expenditure. The applicant shall submit a revised Factor Six (Financial Schedules) upon request by the Department. The applicant is advised that an increase in equity may be necessary to assure the financial feasibility of the project.

9. The applicant shall, at the time of licensure, seek Medicare certification for its eligible Level II beds.

Staff's recommendation was based on the following findings:

1. The applicant proposes construction of a three-story addition to the existing 28 Level IV bed Mercy Center located at 101 Barry Road, Worcester, MA, to replace and relocate 120 Level II beds from the existing 137 Level II bed Saint Francis Home located at 101 Plantation Street in Worcester, MA The Project also involves substantial renovation of the Mercy Center to convert existing residential space to administrative offices and patient rehabilitation and activity services, and upgrade the dietary and laundry services.

2. The health planning process for this project is satisfactory.

3. Consistent with the Determination of Need Guidelines for Nursing Facility and Renovation (Guidelines), the applicant has demonstrated need for new construction to replace and relocate 120 existing Level II beds, and substantial renovation to convert existing residential space to administrative offices and patient rehabilitation and activity services, and upgrade the dietary laundry services.

4. The project, with adherence to certain conditions, meets the operational objectives factor of the Guidelines.

5. The project, with adherence to certain conditions, meets the standard compliance factor of the Guidelines.

6. The recommended maximum capital expenditure of $11,663,575 (January 2004 dollars) is reasonable compared to similar, previously approved projects.

7. The recommended incremental operating costs of $543,159 (January 2004 dollars) are reasonable based on similar, previously approved projects. All operating costs are subject to review by the Division of Health Care Finance and Policy and third party payors according to their policies and procedures.

8. The project is financially feasible and within the financial capability of the applicant.

9. The project meets the relative merit requirements of the Guidelines.

10. The Division of Health Care Finance and Policy submitted comments related to the financial feasibility of the project.

11. The project is exempt from the community health initiatives requirement.

12. The Elena King, Joseph Brazeau, Joyce Richard, James Izatt, and Constance Auger TTGs registered in connection with the proposed project, and submitted written comments opposing the project. A public hearing was not requested.

COMPLIANCE MEMORANDUM: PREVIOUSLY APPROVED DoN PROJECT NO. 4-1401 OF MARIAN MANOR FOR THE AGED AND INFIRM, INC.:

Ms. Joyce James, Director, Determination of Need Program, presented compliance memorandum of Project No. 4-1401 of Marian Manor to the Council. Ms. James indicated in her presentation and memorandum to the Council that Marian Manor is requesting:

a. Extension of the DoN authorization period to January 1, 2007;
b. Transfer of site and replacement of the 366 –bed Marian Manor for the Aged and Infirm, Inc. from 130 Dorchester Street, Boston, MA to a 246-bed facility on land in Quincy Hills known as 'Bates Parcel' shown on the plan entitled ALTA/ACSM Land Title Survey Quarry Hill Drive in Quincy, MA;
c. Decreases in total gross square feet (GSF) from 275,465 to 184,392 and the allowable inflation-adjusted maximum capital expenditure (MCE) from $49,726,014 (June 2004 dollars) to $37,581,972 (June 2004 dollars); and
d. Increase the equity contribution toward the MCE to18.6%.

Ms. James noted that the request to extend the authorization period was no longer necessary due to the action the Public Health Council took on October 24, 2000, extended the authorization periods for replacement and substantial renovation of nursing and rest home projects until January 1, 2007. Ms. James's analysis states, "The documentation supporting the transfer of site of the facility from South Boston to 'Bates Parcel' in Quincy indicates that during the post-planning and development phase of the project, the architects, engineers and financial advisors hired by the holder to implement the project determined that after careful analysis of the existing site, local restrictions, and the construction and work schedule required, it was not feasible to replace and operate Marian Manor at the same time. For example, the limited space at the existing site would require multiple phases of shut down, unacceptable relocation of residents, and disruption to residents during demolition and construction. Also, the work schedule would be extended over several years resulting in exorbitant

project costs. According to the documentation, the holder sought to acquire a suitable alternate site in the community, but was always outbid. For example, the holder made an offer of $5 million to $6 million for the Court Square Press Property, which was eventually sold to real estate developers for $14 million. Under a Purchase and Sale Agreement, the holder was able to acquire a new site, 8.5 acres in Quincy Hill, known as 'Bates Parcel' on the ALTA/ACSM Land Title Survey Quarry Hill Drive in Quincy, MA. The holder also notes that the new site is approximately seven miles from the Boston site, so that the new facility will continue to serve the same urban markets that the existing facility currently serves. To enhance continuity of care, the new site will also include a new Independent Living Facility with 138-units and an undetermined number of new Assisted Living units."

Ms. James noted further that the proposed transfer of site satisfies the Transfer of Site Procedures standard found at 105 CMR 100.720 (H)(3) that it will not result in relocation of more than 25 miles from the original approved site. Regarding the replacement of Marian Manor's 215 Level II, 140 Level III, and 11 Level IV beds with 246 Level II beds at the new site, additional information submitted by the holder at Staff's request indicates that the decrease in the number of beds to be replaced is not a result of low occupancy, but of the holder's interest in maintaining an onsite continuum of care which limits the number of SNF (Level II) beds that can be built on the new site. The holder will request from the Division of Health Care Quality an upgrade of the Level III beds to Level II for a total bed complement of 246 Level II beds. The holder notes that even at 246 beds, the nursing facility will still be one of the largest in the state. Staff notes that information obtained from the Division of Health Care Finance Policy (DHCFP indicates that Marian Manor's 2003 HCF-1 cost report, the most recent year for which data were available, showed an occupancy rate of 98.4%) confirms that the decrease in the number of beds to be replaced was not due to underutilization of the facility. It is important to note that the Independent Living and Assisted Living Facilities, alternatives to institutional care, are not regulated by the Department of Public Health and are therefore not part of Project No. 4-1401."

Ms. James continued, "The requested 160,392 GSF for new construction of the 246 replacement beds results in 652 GSF/bed which exceed the Department standard of 420 GSF/bed. The supporting documentation indicates that the additional 232 GSF/bed is required to accommodate equipment (including wheel chairs), provide innovative programs for dementia, palliative and restorative care, and create a physical environment that will enhance the quality of care and improve the lives of residents. The holder also states that the 420 GSF/bed recommended by the Department was developed in the 1970s and no longer represents the state-of-the-art facility that the market place now demands. Staff finds the additional GSF/bed reasonable and consistent with similar, previously approved projects. The requested 24,000 GSF for the underground parking garage, decreased from 66,965 GSF, reflects the significant reduction in the scope of the project."

Regarding the MCE, Ms. James noted, "The proposed MCE of $37,581,972 (June 2004 dollars) is $12,144,042 (June 2004 dollars) or 24.4% less than the allowable inflation-adjusted MCE of $49,726,014 (June 2004 dollars). The net effect of this reduction results in new construction cost/GSF of $185.20 for the replacement facility, which is within the allowable inflation-adjusted cost/GSF of $199.89 (June 2004 dollars). The proposed cost/GSF of $56.25, for the underground garage exceeds the allowable inflation-adjusted cost/GSF of $49.55 (June 2004 dollars) for construction of the originally approved underground garage. However, staff notes that even at this

slightly higher cost/GSF, the $1,350,000 (June 2004 dollars) construction costs for the proposed underground garage is significantly less than the originally approved cost of $4,507,146 (June 2004 dollars). Thus, staff finds the cost/GSF for new construction of the replacement facility and underground garage reasonable, and comparable to similar, previously approved projects."

Ms. James said further, "As a condition of approval of the original project, the holder agreed to contribute 12% equity contribution or $5,794,801 (June 2004 dollars) toward the final approved MCE. As part of this amendment, the applicant is proposing $7,000,000 (June 2004 dollars) in equity contribution or 18.6% of the requested $37,581,972 (June 2004 dollars) MCE. The equity contribution will be from a Specific Purpose Fund. Staff's review of the holder's most current audited financial statements, FY 2003, shows sufficient cash and cash equivalents and investments to cover the proposed equity contribution."

In conclusion Staff said, "Staff has examined whether the requested significant changes to the project were reasonable in light of past decisions, were unforeseen at the time the application was filed, and were not reasonably within the control of the holder. As previously discussed, it was only after the holder hired architects, engineers and financial advisors to implement the project that it was determined that the project as approved would not be feasible at the existing site. Consistent with Council's past decisions, staff finds that the proposed significant changes to the project could not have been reasonably foreseen at the time the application was filed and were not reasonably within the control of the holder.…Staff finds that action on the request to extend the period of authorization of the Determination of Need is no longer necessary since the project is covered under the extension for all nursing and rest home replacement and substantial renovation projects previously approved by the Council. Staff also finds that the transfer of site meets the applicable DoN regulations, that the capital costs of the reduced project are reasonable, and that the proposed significant changes could not have been reasonably foreseen at the time the application was filed and were beyond the control of the holder. After careful consideration of the comments submitted by Mr. Palmer, staff still recommends approval with conditions of the proposed amendment to DoN approved Project No. 4-1401."

Mr. Thomas Palmer, a member of the Board of Directors for Friends of the Blue Hills, submitted comments opposing the transfer of site. According to Staff's memorandum, Mr. Palmer's comments raised two concerns. One is that "Bates Parcel", the proposed new site, is being sold to Marian Manor for private development although it was originally planned to be used for public recreation as part of the "Quarry Hills Recreational Complex," a project created by landfill from the publicly funded Big Dig. The other concern is that unstable polluted materials brought from the Big Dig to the Quarry Hills are being discharged into a stream and through the "Bates Parcel." Staff noted that Mr. Palmer's concerns are outside the scope of the Determination of Need Program; however condition #2 has been added to the approval, requiring compliance with MEPA regulations. Mr. Palmer did not testify at the Public Health Council meeting.

Council Member Dr. Sterne asked staff what will happen to the current Medicaid patients at Marian Manor with the proposed bed reductions. He asked, "Is there a promise to these patients for transfer or will they be placed in other facilities?"

Attorney David Roush of Roush & Associates, representing the applicant, replied, "Your question is, how can a 355 bed facility get down the number so that, when the transfer occurs, people aren't dislocated, lose their job, or put out in the street? The answer is that this organization is prepared, financially, to back up the loss that will occur by having an admissions freeze or attrition over a predictable and planned period of time before construction is completed so that the number of residents that are at the existing facility will be basically in balance with the number of services that are available at the new place. The people who work there now will be happily greeted at Quarry Hills. In terms of the Medicaid issue because I think that needs to be addressed, Marian Manor is a leader in the Commonwealth in serving eligible seniors. It has done that for decades and it will continue to do that at Quarry Hills. The reduction in bed size is predicated on the fact that it simply needs to be diversified services, people who historically were served in the nursing home settings, for example, Alzheimer patients, are now often appropriately dealt with by other services, and the Sisters have a lot of interesting ideas about what they might do at that campus…The exception is that there will not be an admissions freeze on short term rehabilitation care (Medicare and managed care patients) only the Long Term Care Medicaid patients."

After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve the request of **Previously Approved DoN Project No. 4-1401 of Marian Manor for the Aged and Infirm, Inc.** for significant changes, based on staff's findings. As approved, this Amendment provides for the transfer of site to "Bates Parcel" shown on the plan entitled ALTA/ACSM Land Title Survey Quarry Hill Drive in Quincy, MA, replacement of 246 beds (215 Level II and 31 Level III), and 184,392 GSF in new construction: 160,392 GSF for construction of the new facility and 24,000 GSF for construction of an underground parking garage. The MCE associated with this amendment is $37,581,972 (June 2004 dollars), itemized as follows:

Land Costs:	$	
Land Acquisition		1,500,000
Other Non-Depreciable Land Development		1,050,000
Total Land Costs		2,550,000
Construction Costs:		
Construction Contract (including bonding contract)		27,054,923
Architectural and Engineering Costs		2,650,000
Pre- and Post-Filing Planning and Development Costs		53,000
Other: Rehabilitation Equipment		200,000
Other: Computer Equipment		50,000
Other: Parking Garage		1,350,000
Net Interest Expense During Construction		1,446,309
Major Movable Equipment		782,280
Total Construction Costs approval of this project		33,586,512
Financing Costs:		
Cost of Securing Financing		1,445,460
Total Financing Costs		1,445,460
Estimated Total MCE	$	37,581,972

The conditions accompanying this approval are as follows:

1. The holder shall contribute 18.6% equity contribution toward the final approved MCE.

2. The holder shall comply with Massachusetts Environmental Policy Act (MEPA) Regulations prior to final approval of architectural plans and specifications.

3. All other conditions attached to the original approval of this project, with exception of the equity contribution, shall remain in effect.

The meeting adjourned at 11:30 a.m.

_____
Christine C. Ferguson
Chair

LMH/lmh